NORTH COAST
CLINICS NETWORK

Redwoods Rural
HEALTH CENTER

Quality Improvement Storyboard

Redwoods Rural Health Center
Social Determinants of Health Screening

Aim: By 9/20/2022, Redwoods Rural Health Center will select a social health needs screening tool, screen 20 patients, and refer them to social needs resources.

Plan

Measures:
Outcome Measures:

- % of patients screened who screen positive for social health needs
- % of patients who screen positive that accept social health needs referral

Process Measures:

- % of patients identified to be screened who consent and are screened for social health needs
- % of patients who screen positive that are at highest risk (stratify for outreach)

Prediction:

- RRHC hypothesized that Medi-Cal (PHC assigned) patients and Sliding Fee Scale patients would have the highest needs identified through social health needs screening.

Do

Changes Being Tested:

- Review and select a social health needs screening tool to implement.
- Selected the PRAPARE screening tool; clinicians reviewed the tool and determined which questions will be used for screening patients (adapted tool)
- Identified that screening would be tested on a population of patients that represent adults who are either Partnership HealthPlan (PHC) assigned patients or are on a sliding fee scale.
- Utilized electronic intake system, Phreesia, to administer survey as part of pre-visit preparation. Screening results would be auto-populated in NextGen.
- Patients with 1 or more social health needs identified during screening would be referred to a case manager.

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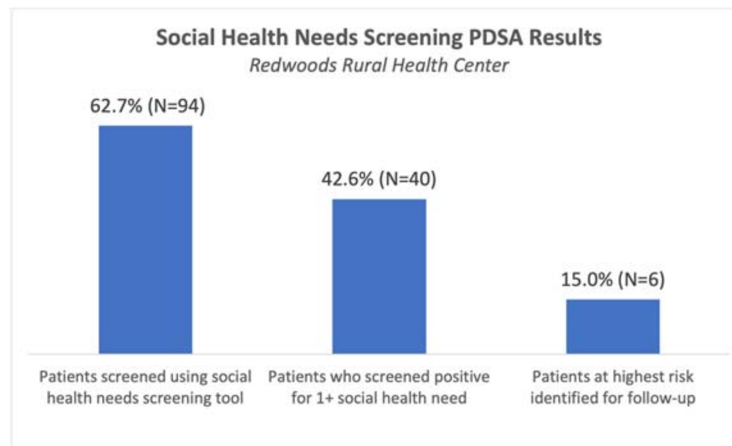
Study

Results:

- Due to a system glitch, the social health needs survey went to a wider patient population than planned, and resulted in a total of 94 patients being screened as part of the PDSA.
- Due to the volume of positive screens (42.6%) and tight PDSA deadline, the Program Manager stratified the patients by highest risk to outreach to first. Highest risk patients were those who felt unsafe (3%) and those "afraid of partner" (3%).
- RRHC has internal resources to aid patients with social health needs, such as food pantry, transportation, phone chargers, sleeping bags etc. The highest needs were in "unable to obtain needs" category, specifically: phone (19%), food (17%), utilities (16%), and childcare (13%).



Act

Future Plans:

- The EHR vendor (NextGen) was slow to respond, and the PRAPARE template was not installed into EHR. If available, RRHC will seek to test use of template for screening for easier access and retrieval of screening data.
- RRHC was able to deploy the screening tool via Phreesia as part of the pre-visit registration according to the plan, with minimal negative impact.
- RRHC is planning to test the Phreesia to EHR data flow, EHR data reporting and plan to spread the workflow in January 2023 beginning with CalAIM ECM/CS patients.
- Case Managers will continue to outreach to all patients screened positive to connected them with resources.
- Social health needs of the patients' screened were found to be high.
- The PDSA revealed wider patient populations (e.g., Medicare, commercially insured) presented with needs than anticipated.